Office of the Inspector General for Mental Health,
Mental Retardation and Substance Abuse Services

Commonwealth Center for Children and Adolescents
Staunton, Virginia
Inspection

James W. Stewart, III / Inspector General

OIG Report #167-08
Issued: December 10, 2008

The Office of the Inspector General for Mental Health, Mental Retardation & Substance Abuse Services (OIG) conducted an inspection at the Commonwealth Center for Children and Adolescents (CCCA) in Staunton, Virginia. An unannounced visit occurred on November 1, 2008 with an additional site-visit on November 3, 2008. Over the course of the two day inspection, interviews were conducted with 27 members of the staff including administrative, clinical, and direct care staff. In addition to staff interviews, surveys were completed with 29 additional members of the direct care staff across all shifts. Observations regarding unit activities occurred on all three shifts, including weekend shifts. Staffing patterns were noted, including the use of overtime.

Documentation reviews included:

- Ten clinical records or 36% of the records of the children that had experienced seclusion or restraint incidents during the previous quarter (July – September)
- Facility data relevant to the use of seclusion and restraint, staff injuries, utilization reviews, and staff turnover

Additional source of information included:

- DMHMRSAS AVATAR Census Information
- Presentation to the State Human Rights Committee by Carolyn Lankford on October 24, 2008 regarding the State Incentive Grant to Build Capacity for Alternatives to Seclusion and Restraint
- DMHMRSAS Bed Days Utilization Data by Age/Group, HPR and Case Management Community Services Board (CSB)
- *Six Core Strategies for Reducing Seclusion and Restraint Use© Draft Example: Policy and Procedure on Debriefing for Seclusion and Restraint Reduction Projects,* Kevin Huckshorn, Director, NTAC, National Association of State Mental Health Program Directors
- *An Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and Their Families (Budget Item 311-E, 2007 Appropriations Act) July 1, 2007- June 30, 2008*_, Report to the Governor and General Assembly by James Reinhard, MD, DMHMRSAS

Section I – Facility Utilization

Utilization of state-operated psychiatric beds for children and adolescents has been an area of focus for the OIG since 2002. Currently, according to the DMHMRSAS *Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Abuse Services for Children, Adolescents and Their Families (FY2008),* "there are 1,646 residential beds, 290 acute inpatient care beds and 64 state inpatient care beds that specifically target children and adolescents with mental and behavioral health needs. There are no state beds and only one private residential treatment program for adolescents with a substance use disorder".

CCCA is the only inpatient facility operated by DMHMRSAS that is dedicated solely to the care and treatment of children and adolescents. This 48-bed freestanding facility is located in Staunton and has been in operation at its current site (adjacent to Western State Hospital) since 1996. CCCA serves children and adolescents age 4 up to the age of 18. The facility's service area includes all 40 community services boards across the Commonwealth. The only other state-operated inpatient beds are located at Southwestern Virginia Mental Health Institute (SWVMHI) in Marion, Virginia where a 16 bed unit is operated for adolescents (age 13 up to the age of 18).

CCCA works with the referring community services boards to determine whether an alternative plan to avoid hospitalization can be developed. Administrators report that multiple factors are considered at the time of admission including:

- The person's history in treatment, including current clinical presentation,
- The lethality and risks associated with the person's symptoms,
- The family's capacity for coping with the situation, and
- The community's capacity to safely serve the individual in an alternate setting

Individuals admitted to CCCA have a primary diagnosis of mental illness. According to information provided by the facility, approximately 65% of the adolescents served have co-occurring mental health and substance use disorder (MH/SA) diagnoses. A majority of the children and adolescents admitted also have significant behavior problems.

During FY2008, 632 persons were served at the facility. Of this number:

- 269 (43%) were females and 363 (57%) males
- 153 or 23% ranged from the age of 0-12; 479 (76%) were in the age range of 13-18 years old.
- 113 (18%) were classified as forensic admissions; of these 62% (70) were identified for court-ordered evaluations
- 519 (82%) were civil admissions.

On the last day of the inspection (November 3, 2008), the facility had a census of 27 or a bed occupancy of 56%. The regional distribution of home CSBs for the children hospitalized on November 3, 2008 was:

- HPR I (northwest) 8 (30%)
- HPR II (north) 5 (19%)
- HPR III (southwest) 2 (7%)
- HPR IV (central) 7 (26%)
- HPR V (east) 5 (18%)

The table below provides information regarding the utilization of the facility over the last five fiscal years:

CCCA UTILIZATION DATA FOR FY04 THROUGH FY08					
	FY04	**FY05**	**FY06**	**FY07**	**FY08**
Number of Admissions	479	537	521	558	605
Number of Discharges	491	538	510	561	601
Number of Readmissions Within 30 days	42	40	45	42	48
Average Daily Census	33.4	29	31.5	34.3	33
Average LOS (days)	27.6	19.6	22.2	22.7	20.2
Median LOS (days)	15	13	15	14	13
Total Persons Served*	511	557	540	588	632
% Bed Occupancy	70%	60%	66%	71%	69%
Cost Per Bed Day	$776.06	$943.46	$920.16	$914.92	$987.00
Total Inpatient Days	12219	10577	11514	12510	12114
# 100 Days and Over LOS	20	2	7	9	11
% of Total Discharges	4.07%	0.37%	1.37%	1.60%	1.83%
# 7 Days and Under LOS	93	133	119	135	169
% of Total Discharges	18.94%	24.72%	23.33%	24.06%	28.12%

Source: CCCA Utilization Management Database
* Total = End of Month Census + Discharges

- There were 605 admissions at CCCA during FY08. This represents an 8% increase in admissions over FY07. 78% of all bed use days for children and adolescents for the 64 state-operated beds occurred at CCCA. Facility administrators report that the increase in admissions has been attributed to limited community resources for dealing with children and adolescents during the acute phase of their illnesses, more forensic admissions, and increasingly diagnostically complicated cases.
- The number of persons served annually has increased steadily from 511 in FY04 to 632 in FY08, a 19% increase over five years. The number of individuals

readmitted to the facility within 30 days of discharge during FY08 represented 8% of the admissions.

- Unit 4 (adolescent unit) had the highest number of admissions for FY08 with 172 or 29%.
- The average daily census of 33 in FY08 is essentially the same as FY04 at 33.4.
- More than a quarter (28.12%) of the discharges that occurred in FY08 took place in a period of less than 7 days.
- Only 1.83% or 11 discharges that occurred in FY08 took place in a period of 100 days or over.
- The average length of stay at CCCA has dropped 27% over the past five years from 27.6 days to 20.2 days.
- The median LOS for FY08 is 13 days. This is compared to the median LOS for FY07 which was 14 days.
- The majority of children discharged (62%) returned to their family residence.

The table below outlines the type of discharge placements for all persons discharged from CCCA during FY2008.

FY08 Type of Discharge Placement	Actual Discharge Placements	% of Discharges
Family Residence	370	61.56%
Own Home	1	0.17%
Virginia State Facility (DMHMRSAS)	2	0.33%
Other	11	1.83%
Home of Non-Relative	4	0.67%
MH Residential Treatment Center	87	14.48%
MH Group Home/Halfway House	23	3.83%
MH Supervised Apartment	2	0.33%
MH Residential Respite/Emerg Shelter	3	0.50%
MH Specialized Foster Care	11	1.83%
Jail/Detention	84	13.98%
Corrections	3	0.50%
Grand Total	601	100.00%

Source: CCCA Data Management (Avatar)

All civil admissions to the facility are prescreened by CSB emergency services. This screening includes an assessment to determine if less restrictive alternatives are available in the community.

The following table shows the number of admissions in FY08 by community services boards. The table on the left is sorted alphabetically; the table on the right is sorted from highest number of admissions to lowest.

CSB	Number of Admissions
Alexandria	11
Alleghany Highlands	7
Arlington	11
Blue Ridge	8
Central Virginia	36
Chesapeake	4
Chesterfield	14
Colonial	2
Crossroads	19
Cumberland Mountain	7
Danville-Pittsylvania	1
Dickenson County	1
District 19	17
Eastern Shore	6
Fairfax-Falls Church	38
Goochland-Powhatan	3
Hampton-Newport News	17
Hanover	2
Harrisonburg-Rockingham	18
Henrico Area	37
Highlands	1
Loudoun	14
Middle Peninsula Northern	6
Mount Rogers	5
New River Valley	35
Norfolk	8
Northwestern	24
Piedmont	5
Planning District 1	3
Portsmouth	2
Prince William County	59
Rappahannock Area	31
Rappahannock Rapidan	23
Region Ten	31
Richmond BHA	38
Rockbridge Area	10
Southside	5
Valley	36
Virginia Beach	6
Western Tidewater	0
TOTAL	601

CSB	CSB Region	Highest to Lowest
Prince William County	2	59
Fairfax-Falls Church	2	38
Richmond BHA	4	38
Henrico Area	4	37
Central Virginia	1	36
Valley	1	36
New River Valley	3	35
Rappahannock Area	1	31
Region Ten	1	31
Northwestern	1	24
Rappahannock Rapidan	1	23
Crossroads	4	19
Harrisonburg-Rockingham	1	18
District 19	4	17
Hampton-Newport News	5	17
Chesterfield	4	14
Loudoun	2	14
Alexandria	2	11
Arlington	2	11
Rockbridge Area	1	10
Blue Ridge	3	8
Norfolk	5	8
Alleghany Highlands	3	7
Cumberland Mountain	3	7
Eastern Shore	5	6
Middle Peninsula Northern	5	6
Virginia Beach	5	6
Mount Rogers	3	5
Piedmont	3	5
Southside	4	5
Chesapeake	5	4
Goochland-Powhatan	4	3
Planning District 1	3	3
Colonial	5	2
Hanover	4	2
Portsmouth	5	2
Danville-Pittsylvania	3	1
Dickenson County	3	1
Highlands	3	1
Western Tidewater	5	0
TOTAL		601

Source: DMHMRSAS Avatar

The total population of Virginia in FY08 was approximately 7,567,700 persons. Of this number 1,863,274 were children 0 through 17 years of age. The following two tables provide the bed day utilization per 50,000 population (0 through 17) for the 40 community services boards:

CCCA Bed Days Utilized Per CSB For FY 2008 Sorted Alphabetically						
CSB	**0-17 Population**	**CSB Region**	**Urban/Rural**	**0-17 Population per 50K**	**Bed Days Used at CCCA**	**Bed Days Utilized at CCCA per 50K**
Alexandria	24,912	2	Urban	0.50	277	556.0
Alleghany Highlands	4,995	3	Rural	0.10	86	860.9
Arlington	33,551	2	Urban	0.67	119	177.3
Blue Ridge	55,636	3	Urban	1.11	127	114.1
Central Virginia	52,916	1	Rural	1.06	866	818.3
Chesapeake	61,522	5	Urban	1.23	119	96.7
Chesterfield	78,781	4	Urban	1.58	528	335.1
Colonial	34,663	5	Urban	0.69	107	154.3
Crossroads	21,570	4	Rural	0.43	291	674.5
Cumberland Mountain	20,145	3	Rural	0.40	165	409.5
Danville-Pittsylvania	24,894	3	Rural	0.50	16	32.1
Dickenson County	3,351	3	Rural	0.07	10	149.2
District 19	40,263	4	Rural	0.81	548	680.5
Eastern Shore	12,060	5	Rural	0.24	247	1,024.1
Fairfax-Falls Church	267,650	2	Urban	5.35	1,106	206.6
Goochland-Powhatan	10,007	4	Rural	0.20	64	319.8
Hampton-Newport News	86,052	5	Urban	1.72	293	170.2
Hanover	25,212	4	Urban	0.50	31	61.5
Harrisonburg-Rockingham	25,017	1	Rural	0.50	348	695.5
Henrico Area	78,646	4	Urban	1.57	772	490.8
Highlands	14,048	3	Rural	0.28	9	32.0
Loudoun	74,857	2	Urban	1.50	378	252.5
Middle Peninsula NN	29,808	5	Rural	0.60	81	135.9
Mount Rogers	25,313	3	Rural	0.51	72	142.2
New River Valley	31,216	3	Rural	0.62	443	709.6
Norfolk	57,279	5	Urban	1.15	250	218.2
Northwestern	50,149	1	Rural	1.00	454	452.7
Piedmont	30,051	3	Rural	0.60	141	234.6
Planning District 1	19,876	3	Rural	0.40	28	70.4
Portsmouth	26,039	5	Urban	0.52	53	101.8
Prince William County	122,122	2	Urban	2.44	1,241	508.1
Rappahannock Area	86,350	1	Urban	1.73	321	185.9
Rappahannock Rapidan	38,829	1	Rural	0.78	498	641.3
Region Ten	47,982	1	Rural	0.96	415	432.5
Richmond BHA	44,499	4	Urban	0.89	660	741.6
Rockbridge Area	7,673	1	Rural	0.15	81	527.9
Southside	18,869	4	Rural	0.38	145	384.2
Valley	25,480	1	Rural	0.51	565	1,108.7
Virginia Beach	115,725	5	Urban	2.31	126	54.4
Western Tidewater	35,267	5	Rural	0.71	0	0.0
Total	**1,863,274**			**37.27**	**12,081**	**324.2**

Source: DMHMRSAS Bed Utilization Data

CCCA Bed Days Utilized per CSB For FY 2008 Sorted by Bed Days Utilized						
CSB	**0-17 Population**	**CSB Region**	**Urban/Rural**	**0-17 Population per 50K**	**Bed Days Used at CCCA**	**Bed Days Utilized at CCCA per 50K**
Valley	25,480	1	Rural	0.51	565	1,108.7
Eastern Shore	12,060	5	Rural	0.24	247	1,024.1
Alleghany Highlands	4,995	3	Rural	0.10	86	860.9
Central Virginia	52,916	1	Rural	1.06	866	818.3
Richmond BHA	44,499	4	Urban	0.89	660	741.6
New River Valley	31,216	3	Rural	0.62	443	709.6
Harrisonburg-Rockingham	25,017	1	Rural	0.50	348	695.5
District 19	40,263	4	Rural	0.81	548	680.5
Crossroads	21,570	4	Rural	0.43	291	674.5
Rappahannock Rapidan	38,829	1	Rural	0.78	498	641.3
Alexandria	24,912	2	Urban	0.50	277	556.0
Rockbridge Area	7,673	1	Rural	0.15	81	527.9
Prince William County	122,122	2	Urban	2.44	1,241	508.1
Henrico Area	78,646	4	Urban	1.57	772	490.8
Northwestern	50,149	1	Rural	1.00	454	452.7
Region Ten	47,982	1	Rural	0.96	415	432.5
Cumberland Mountain	20,145	3	Rural	0.40	165	409.5
Southside	18,869	4	Rural	0.38	145	384.2
Chesterfield	78,781	4	Urban	1.58	528	335.1
Goochland-Powhatan	10,007	4	Rural	0.20	64	319.8
Loudoun	74,857	2	Urban	1.50	378	252.5
Piedmont	30,051	3	Rural	0.60	141	234.6
Norfolk	57,279	5	Urban	1.15	250	218.2
Fairfax-Falls Church	267,650	2	Urban	5.35	1,106	206.6
Rappahannock Area	86,350	1	Urban	1.73	321	185.9
Arlington	33,551	2	Urban	0.67	119	177.3
Hampton-Newport News	86,052	5	Urban	1.72	293	170.2
Colonial	34,663	5	Urban	0.69	107	154.3
Dickenson County	3,351	3	Rural	0.07	10	149.2
Mount Rogers	25,313	3	Rural	0.51	72	142.2
Middle Peninsula Northern	29,808	5	Rural	0.60	81	135.9
Blue Ridge	55,636	3	Urban	1.11	127	114.1
Portsmouth	26,039	5	Urban	0.52	53	101.8
Chesapeake	61,522	5	Urban	1.23	119	96.7
Planning District 1	19,876	3	Rural	0.40	28	70.4
Hanover	25,212	4	Urban	0.50	31	61.5
Virginia Beach	115,725	5	Urban	2.31	126	54.4
Danville-Pittsylvania	24,894	3	Rural	0.50	16	32.1
Highlands	14,048	3	Rural	0.28	9	32.0
Western Tidewater	35,267	5	Rural	0.71		0.0
Total	**1,863,274**			**37.27**	**12,081**	**324.2**

Source: DMHMRSAS Bed Utilization Data

- Valley Community Services Board had the highest bed usage (1,108.7 days) per population of 50,000. This is the CSB in closest proximity to the Commonwealth Center.
- Prince William CSB had the greatest number of admissions to the Center (59), about 10% of all admissions this past year. The total bed use days for the CSB was 1,241, ranking it as 13th in highest actual bed usage per a population of 50,000.
- Western Tidewater Community Services Board is the only CSB that did not have any admissions to CCCA in FY08.
- Of the ten CSBs with the highest bed day usage per population of 50,000, nine are classified as rural boards. The regional distribution of these 10 CSBs is:
    - Region I – 4 CSBs
    - Region III – 2 CSBs
    - Region IV – 3 CSBs
    - Region V – 1 CSBs
- Of the CSBs classified as urban, Richmond Behavioral Health Authority had the highest bed day utilization per population of 50,000 (741.6) and Virginia Beach CSB had the lowest bed day utilization (54.4).
- Of the ten CSBs with the lowest bed day usage per population of 50,000, 50% are classified as rural boards and 50% as urban boards. The regional distribution of these 10 CSBs is:
    - Region III- 4 CSBs
    - Region IV – 1 CSB
    - Region V - 5 CSBs
- The bed day usage per population of 50,000 by region from highest to lowest was as follows:
    - HPR I (northwest) 530.5
    - HPR IV (central) 478.1
    - HPR II (north) 298.3
    - HPT III (southwest) 239.0
    - HPT V (east) 139.9
- 65% of the total number of bed days used in FY2008 was by rural boards and 35% by urban boards.
- While this inspection focused solely on CCCA, it may be of interest to the reader to see bed utilization statewide for both CCCA (48 beds) and SWVMHI (16 beds). A chart summarizing total utilization of state operated child and adolescent beds can be found in Attachment A. SWVMHI is located in Region III.

Findings and Recommendations

Finding 1.1: DMHMRSAS resources for addressing the mental health and behavioral needs of the children and adolescents in the Commonwealth are underutilized at CCCA.

- With licensed capacity of 48 beds, the average daily census at CCCA was 33 in FY08. Over the past five years this has ranged from a high of 34.3 to a low of 29.

- The bed occupancy rate was 69% in FY08. Over the past five years this has ranged from a high of 71% to a low of 61%.
- CCCA is well-staffed with small units and maintains high staff to children ratios. For example there are five full-time PhD psychologists and five board certified child and adolescent psychiatrists for this 48-bed facility.
- A full complement of professional staffing is maintained even though the census runs well below capacity. This results in CCCA having the highest cost per bed ($987) day of all the DMHMRSAS mental health facilities.
- According to data from the DMHMRSAS Comprehensive Plan for 2008-2014, during the period January through April 2007, "1,680 children and adolescents were on waiting lists for specific CSB mental health services. An additional 234 adolescents were on waiting lists to receive substance abuse treatment".
- As documented in *OIG Report #149-08 / Review of Community Services Boards Child and Adolescent Services*, "Few community services boards offer a large array of child and adolescent services with sufficient capacity to meet the needs of their community. Many community services boards have very limited services available to children. A few have virtually no service system designed especially for children".

Finding 1.2: A significant percentage of admissions to CCCA were stabilized within seven days or less.

- Of the persons served in FY08, 169 or 28.12% were discharged within seven days of admission.
- There have been a number of outcome studies that have demonstrated it is in the best interest of a child, his family and ultimately the community that the child be treated in his community and family setting as opposed to an institutional setting whenever possible. Serving children in their home community can diminish the additional trauma that can result from separation from friends and family and disruption of daily activities, as well as the trauma often associated with institutional care.
- Many of these individuals could be successfully stabilized in the community if more appropriate community based crisis stabilization services, including psychiatric services, were available.

Finding 1.3: A significant percentage of admissions to CCCA were referred as ten-day court ordered evaluations.

- Of the persons served in FY08, 113 (18%) were classified as forensic admissions; 62% (70) of this total were identified for court-ordered evaluations.
- The court-ordered evaluations represent 11% of all the persons served at the facility according to information provided by DMHMRSAS.
- The approximate costs of completing the ten-day evaluations at the FY08 average cost per bed day of $987 is just under $10,000.

- Many of these individuals could be evaluated in the detention center or other setting in the community from which they came if sufficient clinical expertise and funding for these services were available in the child's home community.

Recommendation 1: It is recommended that DMHMRSAS review the current utilization of child and adolescent resources in facility settings and redirect funding in order to provide secure specialized community based crisis stabilization services for children and adolescents and provide appropriate clinical capacity to conduct juvenile forensic evaluations through the CSBs or regional teams.

Section II - State Incentive Grant for Alternatives to Seclusion and Restraint

One of the findings identified by the OIG during the FY2007 inspection at CCCA (OIG Report #145-07) was that the facility continues to have a very high number of behavioral management incidents that result in the use of seclusion and restraint. Despite previous efforts, it was noted that the facility had been unable to sustain any significant reduction in the use of seclusion and restraint in the preceding five years.

In 2007, DMHMRSAS was awarded approximately $214, 000 by SAMSHA to develop alternatives to the use of seclusion and restraint (SR). CCCA was one of the state-operated facilities selected for participation in this initiative. The first year of this three year grant ended in October 2008. The strategies and activities that the facilities are undertaking to reduce the use of seclusion and restraint are based on the Public Health Prevention Model and NASMHPD's, *Six Core Strategies to Reduce the Use of Seclusion and Restraint.*

In brief, the public health prevention model has three levels of prevention activities:

- The first level or primary prevention strategies call for structuring the environment of care and clinical support in a manner that anticipates and plans interventions for handling each individual's risk factors prior to an event occurring. An example is the development of safety plans at the time of admission.
- The second level of prevention strategies calls for a foundation of tools for staff to use at the time that a situation is escalating into a potential crisis such as removing the child from the conflicting situation and/other deescalating techniques.
- The final level of prevention is to develop methods of review such as staff and consumer debriefings in order to assess the situation and develop new strategies for handling similar circumstances if they arise.

The *Six Core Strategies to Reduce the Use of Seclusion and Restraint* outlines strategies for assessing an organization's culture and its readiness for reducing the use of restrictive procedures. The strategies are to be applied broadly to the organization. This starts with the role and commitment of the organization's leadership team in actualizing the changes to reduce seclusion and restraint. The core strategies include activities/interventions that

are consistent with the public health prevention model, such as active supervision, increased clinical contact for direct care staff, and debriefings.

The primary goals for the first year of the grant were to begin the process of organizational assessment, develop a strategic plan for addressing the key elements of the core strategies and initiate early stage interventions.

Findings and Recommendations

Finding 2.1: CCCA engaged in a number of promising activities designed to reduce the use of seclusion and restraint as a result of the facility's participation in the SAMSHA Grant.

- The Center convened a Seclusion and Restraint Steering Committee to oversee implementation of the core strategies. Serving on the committee was a person receiving services.
- The Center developed a strategic plan for implementing the goals identified by the Steering Committee.
- Multiple training events have been completed.
- The Management of Violence and Aggression Survey (MAVAS) was administered to staff and the results reported.
- Two NASMHPD consultants visited the Center to assess the facility's readiness for change. The consultants provided feedback to the organization regarding leadership's commitment to the reduction of seclusion and restraint; the impact of reducing seclusion and restraint on the treatment environment; clinical treatment activities; and how effectively clinical policies, procedures and practices support the mission, vision, and values of both DMHMRSAS and a trauma-informed environment of care.
- Members of the facility leadership team reported that CCCA has revised its organizational structure. This includes having direct care staff report to the unit psychologists to assure that there is clinical link between the child's individualized treatment goals and the activities of direct care activities.
- The creation of safety plans at the time of admission has occurred for some of the children admitted to the facility
- The Center has proposed a number of environmental changes, including adding comfort areas, painting and murals, and softer lighting.

Finding 2.2: Staff, at all levels, voiced a commitment to the reduction of seclusion and restraint initiative and were able to discuss strategies for creating a trauma-informed environment and sustaining the facility's current seclusion and restraint reduction efforts.

- Members of the facility leadership team expressed optimism regarding the current effort to reduce seclusion and restraint. Among the reasons they believe the initiative will be successful are the following:
    - A positive partnership with DMHMRSAS central office that is based on a common goal and vision.

    - A structure and support for identifying realistic goals and strategies through the grant
    - Ongoing assistance and feedback from NASMHPD consultants
    - The recent organizational change that enhances the role of psychologists in providing clinical supervision and support.
- Members of the Psychology Department conveyed that the recent organization change provides them with a structure for providing increased clinical supervision of direct care staff in order:
    - To enhance their skill sets,
    - To assure greater practice consistency across shifts in crisis management and in the provision of treatment objectives, and
    - To increase direct care staff awareness of trauma-informed practices.
- The organizational change also allows members of the psychology staff to provide direct supervision to shift coordinators so that there can be greater links to clinical services and supports around the clock.
- The majority (78%) of the direct care staff interviewed expressed being excited at the proposed organizational changes and being committed to the success of the seclusion and restraint reduction initiative.

Finding 2.3: CCCA eliminated the use of prone restraint effective July 1, 2008.

- Members of the facility's leadership team reported that the effort to eliminate prone restraint began with a philosophical agreement by the leadership team. Related activities included:
    - Assuring that all staff were trained in behavioral management techniques
    - Modifying TOVA training to highlight the elimination of this practice.
    - Holding meetings for direct care staff with the senior leadership team and supervisory staff to listen to and address any concerns they have about the proposed change before the target elimination date
    - Setting a target date and assuring compliance through increased supervision and support.
- 70.4% of the direct care staff surveyed responded positively to the following statement - *The facility's decision to eliminate the use of prone restraints has had positive results.*
- Prior to the total elimination of prone restraints, the facility's use of this restrictive intervention had decreased. The following shows the number of prone restraints documented by the facility in FY08. (Statistics for July through December 2007 were reported in OIG Report #145-07).

Frequency of Prone Restraint Use At CCCA For FY2008													
	July 07	**Aug 07**	**Sept 07**	**Oct 07**	**Nov 07**	**Dec 07**	**Jan 08**	**Feb 08**	**Mar 08**	**Apr 08**	**May 08**	**June 08**	**Total**
All Units	18	19	17	9	3	20	3	5	3	4	4	1	106

Source: CCCA Office of Risk Management Database

Finding 2.4: The use of seclusion and restraint at CCCA decreased 8.9% between FY07 and FY08.

The following two charts show a comparison of the use of seclusion and mechanical restraints between FY07 and FY08.

CCCA Incidents of Seclusion & Mechanical Restraint by Shift FY2007							
	Day	% Day	Evening	% Evening	Night	% Night	Total
Seclusion	263	36%	447	61%	25	3%	735
Mechanical Restraint	48	27%	119	66%	12	7%	179
Total	311	34%	566	62%	37	4%	914

CCCA Incidents of Seclusion & Mechanical Restraint by Shift FY2008							
	Day	% Day	Evening	% Evening	Night	% Night	Total
Seclusion	254	37%	393	58%	34	5%	681
Mechanical Restraint	26	17%	115	76%	11	7%	152
Total	280	34%	508	61%	45	5%	833

Source: CCCA Office of Risk Management Database

- There were 914 incidents of seclusion and restraint in FY07 as compared the 833 combined incidents of seclusion and restraint for FY08. This represents an 8.9% decrease.
- In FY07, there were 735 incidents of seclusion as compared to the 681 incidents in FY08.
- There were 179 incidents of mechanical restraint usage in FY07 and 152 incidents reported for FY08.
- The percentage of incidents per shift were about the same in FY07 and FY08, with the majority of incidents occurring during the evening shift.
- Direct care staff attribute the high incidents of seclusion and restraint during the evening shift to:
    - Limited resources and staff for designing and conducting structured activities
    - Fewer experienced staff scheduled for work during the 2nd shift
    - No active links between the clinical staff and direct care providers, particularly on the weekends.

Recommendation 2: It is recommended that CCCA review and redirect clinical staff and resources in an effort to decrease the incidence of seclusion and restraint during the evening shift.

Finding 2.5: Overall, the clinical records do not consistently reflect an orientation to trauma-informed care practices.

- Even though all of the records reviewed were consumer specific and clearly outlined the reasons for hospitalization and provided for a comprehensive psychosocial history, not all of records reviewed provided a clear assessment of

the abuse or trauma experienced. Slightly more than half of the records documented assessment of abuse or trauma that was witnessed by the consumer. None of the records reviewed identified clear trauma-informed strategies in the consumer's treatment plan.

- 83% of the records reviewed did not identify the consumer's and/or the authorized representative's preferred treatment interventions for behavioral management.
- Only 12.5% of the records reviewed contained a safety plan so that staff are not constantly reacting to specific consumer's aggression or challenging behaviors.
- Almost all of the records reviewed did not contain evidence in the progress notes that issues associated with identified trauma experiences were being actively addressed
- Discharge summaries in a majority of the records reviewed did not reflect the ongoing necessity for treatment to address issues associated with trauma.

Finding 2.6: There was no evidence in the clinical records that clinical debriefings are used to identify alternative treatment strategies that can be used in the future to minimize the use of restrictive procedures.

- The use of restrictive procedures was clearly documented in the clinical record.
- All the incidents documented included the clinical justification for the use of the restrictive intervention.
- There was evidence in each of the records reviewed that debriefings routinely occurred after the use of restrictive intervention.
- None of the incidents in any of the records reviewed showed evidence that the debriefings are used to identify alternative strategies that become part of the consumer's treatment.

Section III – Workforce Development

NASMHPD's Six Core Strategies to Reduce the Use of Seclusion and Restraint states that the goal for workforce development is "to create a treatment environment whose policy, procedures, and practices are grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services and the experiences of our staff. This includes an understanding of the characteristics and principles of trauma informed care systems. It also includes the principles of recovery-oriented systems of care such as person-centered care, choice, respect, dignity, partnerships, self-management, and full inclusion. Intervention is designed to create an environment that is less likely to be coercive or conflictual and is implemented primarily through staff training and education and Human Resources and Development activities."

CCCA, with assistance from the NASMHPD consultants, is exploring a number of objectives for addressing the core strategy for workforce development. Among the objectives being considered are the following:

- Introduce recovery/resiliency, prevention, and performance improvement theory and rational to all staff

- Revise the organizational mission, philosophy, and policies and procedures to address the theory and principles of trauma-informed systems of care.
- Address staff empowerment issues
- Explore unit "rules" with an eye to analyzing them for logic and necessity.

Findings and Recommendations

Finding 3.1: Direct care staff indicate that communication within the facility and the support they receive from more senior staff have improved.

- 82.7% of the staff responded positively to the survey statement - *The senior leadership team has created an open and comfortable work environment for expressing my ideas.*
- When asked on the survey to respond to whether *Communication within the facility between the senior leadership team and direct care staff is effective and provides me with an understanding of the facility's strategic objectives,* a slight majority (55.15%) of direct care staff responded positively.
- 72.4% of the staff had a positive response when asked whether they have received the training they need to effectively reduce the use of seclusion and restraint.
- 92.8% of the staff reported that the skills they have been taught have enabled them to be effective in handling the behavioral challenges of the persons served.
- Staff reported feeling increasingly supported by their supervisors while indicating a desire for more clinical support and supervision.
    - 89.6% of the staff surveyed indicated a positive response to the statement, M*y supervisor is readily available to help me problem-solve options for intervening with individuals with challenging behaviors in lieu of seclusion and restraint.*
    - 93% of the staff reported positively to the comment *My supervisor is readily available to assist me in the physical management of a consumer.*
    - Only 53.6% provided a positive response to the following statement, *When it is necessary for me to engage in the physical management of an individual, the clinical staff are readily available to assist.*
    - 72.4% of the staff surveyed responded positively when asked if they would recommend to others working at CCCA

Finding 3.2: The majority (20 of 29) of staff surveyed reported feeling safe while performing their duties at the facility.

- The staff that reported feeling safe in the environment indicated that this is due primarily to increased training and closer supervision. Six of the 22 staff interviewed reported a correlation between the elimination of prone restraint and staff safety.
- There were 224 reported incidents of staff injury at the facility in FY08. Of these, 68% or 153 incidents resulted during the use of restrictive interventions. This compares to 98% of total incidents in FY07.
- Sixty or 39% of the injuries occurred during incidents of seclusion
- 38% or 58 of the injuries occurred during incidents involving the use of mechanical restraints

- Thirty-five or 23% of the injuries occurred during incidences of physical restraint.

Finding 3.3: The rate of turnover among the direct care staff at the facility remains high.

- The turnover rate for DSA II positions at CCCA was 46.7% for FY08. This is compared to a turnover rate for the same positions of 57.5% in FY07.
- The following table compares the turnover rate for DSA Is and IIs at CCCA during FY07 and FY08.

Turnover of Direct Care Staff at CCCA			
DSAs I & II			
Fiscal Year	Average Filled	Separations	Turnover %
FY07	43.5	25	57.5%
FY08	43	20	46.5%

Source: DMHMRSAS Avatar

- Of the direct care staff that participated in the OIG survey, the average years of service was 16 months. The median length of service was 14 months.
- 87% of the staff answered negatively when asked to respond to the following statement - *During the past 12 months, there have been fewer turnovers in direct care positions.*
- The following table shows the years of service for DSA positions at CCCA as of December 2008.

DSA Positions at CCCA by Length of Service			
	Less the 1 year	**1-2 years**	**3 or more years**
DSA II	23	18	6
DSA III	1	7	10

Source: CCCA HR Database

- 49% of the DSA IIs have been employed at the facility for less than 1 year.
- The majority of DSA IIIs (55%) have 3 or more years of service.
- Of the total of DSA IIs and DSA IIIs, 75% have less than 3 years of service.

Attachment A

Statewide Bed Days Utilized for FY 2008 Sorted Alphabetically								
CSB	**0-17 Population**	**CSB Region**	**Urban/Rural**	**0-17 Population per 50K**	**Bed Days Used at CCCA**	**Bed Days Used at SWVMHI**	**Total Bed Days Used**	**Bed Days Utilized per 50K**
Alexandria	24,912	2	Urban	0.50	277		277	556.0
Alleghany Highlands	4,995	3	Rural	0.10	86		86	860.9
Arlington	33,551	2	Urban	0.67	119		119	177.3
Blue Ridge	55,636	3	Urban	1.11	127	957	1,084	974.2
Central Virginia	52,916	1	Rural	1.06	866	5	871	823.0
Chesapeake	61,522	5	Urban	1.23	119		119	96.7
Chesterfield	78,781	4	Urban	1.58	528		528	335.1
Colonial	34,663	5	Urban	0.69	107		107	154.3
Crossroads	21,570	4	Rural	0.43	291		291	674.5
Cumberland Mountain	20,145	3	Rural	0.40	165	140	305	757.0
Danville-Pittsylvania	24,894	3	Rural	0.50	16	180	196	393.7
Dickenson County	3,351	3	Rural	0.07	10	108	118	1,760.6
District 19	40,263	4	Rural	0.81	548	13	561	696.7
Eastern Shore	12,060	5	Rural	0.24	247		247	1,024.1
Fairfax-Falls Church	267,650	2	Urban	5.35	1,106		1,106	206.6
Goochland-Powhatan	10,007	4	Rural	0.20	64		64	319.8
Hampton-Newport News	86,052	5	Urban	1.72	293		293	170.2
Hanover	25,212	4	Urban	0.50	31		31	61.5
Harrisonburg-Rockingham	25,017	1	Rural	0.50	348		348	695.5
Henrico Area	78,646	4	Urban	1.57	772		772	490.8
Highlands	14,048	3	Rural	0.28	9	115	124	441.4
Loudoun	74,857	2	Urban	1.50	378		378	252.5
Middle Peninsula Northern	29,808	5	Rural	0.60	81		81	135.9
Mount Rogers	25,313	3	Rural	0.51	72	490	562	1,110.1
New River Valley	31,216	3	Rural	0.62	443	787	1,230	1,970.1
Norfolk	57,279	5	Urban	1.15	250		250	218.2
Northwestern	50,149	1	Rural	1.00	454		454	452.7
Piedmont	30,051	3	Rural	0.60	141	126	267	444.3
Planning District 1	19,876	3	Rural	0.40	28	474	502	1,262.8
Portsmouth	26,039	5	Urban	0.52	53		53	101.8
Prince William County	122,122	2	Urban	2.44	1,241		1,241	508.1
Rappahannock Area	86,350	1	Urban	1.73	321	1	322	186.5
Rappahannock Rapidan	38,829	1	Rural	0.78	498		498	641.3
Region Ten	47,982	1	Rural	0.96	415		415	432.5
Richmond BHA	44,499	4	Urban	0.89	660	20	680	764.1
Rockbridge Area	7,673	1	Rural	0.15	81		81	527.9
Southside	18,869	4	Rural	0.38	145	9	154	408.1
Valley	25,480	1	Rural	0.51	565	8	573	1,124.4
Virginia Beach	115,725	5	Urban	2.31	126		126	54.4
Western Tidewater	35,267	5	Rural	0.71			0	0.0
Total	**1,863,274**			**37.27**	**12,081**	**3,433**	**15,514**	**416.3**

Source: DMHMRSAS Bed Utilization Data

Statewide Bed Days Utilized for FY 2008 Sorted by Bed Utilization								
CSB	**0-17 Population**	**CSB Region**	**Urban/Rural**	**0-17 Population per 50K**	**Bed Days Used at CCCA**	**Bed Days Used at SWVMHI**	**Total Bed Days Used**	**Bed Days Utilized per 50K**
New River Valley	31,216	3	Rural	0.62	443	787	1,230	1,970.1
Dickenson County	3,351	3	Rural	0.07	10	108	118	1,760.6
Planning District 1	19,876	3	Rural	0.40	28	474	502	1,262.8
Valley	25,480	1	Rural	0.51	565	8	573	1,124.4
Mount Rogers	25,313	3	Rural	0.51	72	490	562	1,110.1
Eastern Shore	12,060	5	Rural	0.24	247		247	1,024.1
Blue Ridge	55,636	3	Urban	1.11	127	957	1,084	974.2
Alleghany Highlands	4,995	3	Rural	0.10	86		86	860.9
Central Virginia	52,916	1	Rural	1.06	866	5	871	823.0
Richmond BHA	44,499	4	Urban	0.89	660	20	680	764.1
Cumberland Mountain	20,145	3	Rural	0.40	165	140	305	757.0
District 19	40,263	4	Rural	0.81	548	13	561	696.7
Harrisonburg-Rockingham	25,017	1	Rural	0.50	348		348	695.5
Crossroads	21,570	4	Rural	0.43	291		291	674.5
Rappahannock Rapidan	38,829	1	Rural	0.78	498		498	641.3
Alexandria	24,912	2	Urban	0.50	277		277	556.0
Rockbridge Area	7,673	1	Rural	0.15	81		81	527.9
Prince William County	122,122	2	Urban	2.44	1,241		1,241	508.1
Henrico Area	78,646	4	Urban	1.57	772		772	490.8
Northwestern	50,149	1	Rural	1.00	454		454	452.7
Piedmont	30,051	3	Rural	0.60	141	126	267	444.3
Highlands	14,048	3	Rural	0.28	9	115	124	441.4
Region Ten	47,982	1	Rural	0.96	415		415	432.5
Southside	18,869	4	Rural	0.38	145	9	154	408.1
Danville-Pittsylvania	24,894	3	Rural	0.50	16	180	196	393.7
Chesterfield	78,781	4	Urban	1.58	528		528	335.1
Goochland-Powhatan	10,007	4	Rural	0.20	64		64	319.8
Loudoun	74,857	2	Urban	1.50	378		378	252.5
Norfolk	57,279	5	Urban	1.15	250		250	218.2
Fairfax-Falls Church	267,650	2	Urban	5.35	1,106		1,106	206.6
Rappahannock Area	86,350	1	Urban	1.73	321	1	322	186.5
Arlington	33,551	2	Urban	0.67	119		119	177.3
Hampton-Newport News	86,052	5	Urban	1.72	293		293	170.2
Colonial	34,663	5	Urban	0.69	107		107	154.3
Middle Peninsula Northern	29,808	5	Rural	0.60	81		81	135.9
Portsmouth	26,039	5	Urban	0.52	53		53	101.8
Chesapeake	61,522	5	Urban	1.23	119		119	96.7
Hanover	25,212	4	Urban	0.50	31		31	61.5
Virginia Beach	115,725	5	Urban	2.31	126		126	54.4
Western Tidewater	35,267	5	Rural	0.71			0	0.0
Total	**1,863,274**			**37.27**	**12,081**	**3,433**	**15,514**	**416.3**

Source: DMHMRSAS Bed Utilization Data

Attachment B

Direct Care Staff Survey

	Strongly Agree	Agree	Disagree	Strongly Disagree
I was asked to provide input to the development of the facility's current seclusion and restraint initiative.	7.1%	46.4%	32.1%	14.3%
I am generally involved in decision making that affects my job.	17.2%	41.4%	37.9%	3.4%
The senior leadership team has created an open and comfortable work environment for expressing my ideas.	31.0%	51.7%	17.2%	0.0%
Communication within the facility between the senior leadership team and direct care staff is effective and provides me with an understanding of the facility's strategic objectives.	3.4%	51.7%	27.6%	17.2%
The facility's decision to eliminate the use of prone restraints has had positive results.	11.1%	59.3%	25.9%	3.7%
I have received the training I need to effectively reduce the use of seclusion and restraint.	3.4%	69.0%	20.7%	6.9%
The skills I have been taught have enabled me to be effective in handling the behavioral challenges of the persons I serve.	10.7%	82.1%	7.1%	0.0%
I am able to interact with members of the senior leadership team because they are frequently (several times per week) on my unit.	10.3%	44.8%	31.0%	13.8%
When it is necessary for me to engage in the physical management of an individual, the clinical staff are readily available to assist.	14.3%	39.3%	32.1%	14.3%
My supervisor is readily available to assist me in the physical management of a consumer.	62.1%	31.0%	6.9%	0.0%
My supervisor is readily available to help me problem-solve options for intervening with individuals with challenging behaviors in lieu of seclusion and restraint.	58.6%	31.0%	10.3%	0.0%
I am treated with respect by the people I work with.	32.1%	46.4%	21.4%	0.0%
Employees work well together to solve problems and get the job done.	20.7%	69.0%	10.3%	0.0%
During the past 12 months, there have been fewer turnovers in direct care positions.	0.0%	13.6%	40.9%	45.5%
I would recommend others to work for this facility.	0.0%	72.4%	27.6%	0.0%